| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---|------------------------------|------------|-------------|--|----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | | 00 | COMPLETED |
| | | | | LDING | | 06/05/2014 |
| | | | B. WIN | | | 00/00/2011 |
| NAME OF P | ROVIDER OR SUPPLIEF | 8 | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | | / 96TH ST | |
| RITTENH | IOUSE SENIOR LI | VING OF INDIANAPOLIS | | INDIAN | IAPOLIS, IN 46260 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | l | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE |
| R000000 | | | | | | |
| 11000000 | | | | | | |
| | This misit are s | m - Ctata Danidantial | DO | 00000 | DISCLAIMER: Preparation | , |
| | | or a State Residential | KUC |)0000 | and implementation of this | ' |
| | Licensure Surve | y. | | | plan of correction does not | |
| | | | | | constitute admission or | |
| | June 3, 4 and 5, | 2014 | | | | |
| | ,, | | | | agreement by Rittenhouse | of |
| | Easilitesl | 002292 | | | Senior Living of Indianapolis | |
| | Facility number: | | | | the truth of the facts, finding or other statements as allege | |
| | Provider number | | | | by the preparer of the | s u |
| | AIM number: N/A Survey Team: Sandra Nolder, RN, Team Coordinator | | | | survey/inspection dated Jun | |
| | | | | | 5, 2014. Rittenhouse Senior | |
| | | | | | Living of Indianapolis | |
| | | | | | specifically reserves the righ | |
| | | | | | to move to strike or exclude | " |
| | Gloria Bond, RN | N | | | this document as evidence in | <u> </u> |
| | | | | | any civil, criminal or | " |
| | Census bed type | : | | | administrative action not | |
| | Residential: 77 | | | | related directly to the licensi | na |
| | Total: 77 | , | | | and/or certification of this | ''9 |
| | 101.11 | | | | facility or provider. | |
| | | | | | Rittenhouse Senior Living | |
| | Census payor ty | pe: | | | respectfully requests a pape | r |
| | Medicaid: 7 | | | | review for compliance for the | |
| | Other: 70 | | | | annual survey. | |
| | Total: 77 | | - [| | aa. oarvoy. | |
| | 10001. // | | | | | |
| | | | | | | |
| | Sample: 8 | | | | | |
| | | | | | | |
| | These state findi | ings are cited in | | | | |
| | accordance with | 410 IAC 16.2. | | | | |
| | | - | | | | |
| | Ossalitas Die | | | | | |
| | | was completed by | | | | |
| | Tammy Alley R | N on June 11, 2014. | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| R000036 | 410 IAC 16.2-5-1. | 2(k)(1-2) | | | | |
| | | | | | 1 | I . |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 1 of 47

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING | E CONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|---|------------|
| | | | B. WING | | 06/05 | /2014 |
| | PROVIDER OR SUPPLIEF | VING OF INDIANAPOLIS | 125 | EET ADDRESS, CITY, STATE, ZIP CODE 1 W 96TH ST IANAPOLIS, IN 46260 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | |
| | resident 's physic legal representation noticed: (1) a significant dephysical, mental, (2) a need to alter that is, a need to form of treatment consequences or of treatment. Based on observed record review, the resident's Physignificant changer reviewed for significant changer reviewed for significant that is, a need to form of treatment. Based on observed record review, the resident's Physignificant changer reviewed for significant changer reviewed for significant that is a reviewed for significant | st immediately consult the ian and the resident 's we when the facility has believe when the facility has believe when the resident 's per psychosocial status; or treatment significantly, discontinue an existing due to adverse to commence a new form ation, interview and the facility failed to notify systems regarding ges for 2 of 8 residents inificant changes. Ind #35) Street record was reviewed 2 P.M. Diagnoses are not limited to, so type II, hypothyroidism, pression. | R000036 | Residents' Rights 1) Will corrective action(s) will be accomplished for those res found to have been affected the deficient practice: Resi #11Call orders / parameter Blood sugars results reque for appropriate notification resident physician. Reside Physician was notified reshortness of breath. Lied Nurses for residents #11 at will receive education rest facility "Notification Policy – Physicians, Residents and Responsible Parties". How the facility will identify residents having the potent be affected by the same depractice and what corrective action will be taken: All residents have the potential affected. 3) What measure will be put into place or what systemic changes the facility make to ensure that the desired. | hat idents d by ident s re: sted of int #35 censed ind #35 he 2) other tial to efficient e il to be irres at ty will ficient The elive | 07/25/2014 |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 2 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE C | X3) DATE SURVEY | | |
|--|---------------------|--------------------------------|-----------------|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | |
| | | | B. WING | | 06/05/2014 | |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | ER | | V 96TH ST | | |
| RITTEN | HOUSE SENIOR L | IVING OF INDIANAPOLIS | | NAPOLIS, IN 46260 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | The resident's " | | | the facility policy "Notification | | |
| | Monitoring For | m" dated February 2014, | | Policy – Physicians, Residents and Responsible Parties". This | | |
| | and "Nurse's No | otes" indicated the | | training shall also include prop | | |
| | following low b | blood sugars lacked | | documentation in the clinical | ,,,, | |
| | _ | that the Physician was | | record of these notifications. | | |
| | notified. | - | | Review of new orders, signific | ant | |
| | 2/02/14Pre-di | nner blood sugar-69. | | changes in resident condition | | |
| | | nner blood sugar-53. | | contained in the twenty-four (2 hour reports will be reviewed by | | |
| | | ne blood sugar-64. | | Resident Care Director and or | | |
| | | ne blood sugar-68. | | their designee to ensure | | |
| | | nner blood sugar-62. | | compliance with policy. 4) | l l | |
| | | · · | | How the corrective action(s) w | /ill | |
| | 2/26/14Deuill | ne blood sugar-58. | | be monitored to ensure the deficient practice will not recui | | |
| | T :1 41 11 | IDI 1.01 | | i.e., what quality assurance | , | |
| | The resident's " | | | program will be put into place: | | |
| | _ | m" dated March 2014, | | The results of the review of ne | | |
| | | otes" indicated the | | orders, significant changes in | | |
| | _ | blood sugars lacked | | resident condition contained in | | |
| | documentation | that the Physician was | | the twenty-four (24) hour repo are completed by Resident Ca | | |
| | notified. | | | Director and or their designee | l l | |
| | 3/01/14Bedtir | ne blood sugar-63. | | daily Monday through Friday f | l l | |
| | 3/08/14Pre-di | nner blood sugar-52. | | four (4) weeks and one (1) time | ie a | |
| | 3/14/14Pre-di | nner blood sugar-49. | | week thereafter. Results of | | |
| | 3/21/14Bedtir | ne blood sugar-61. | | review will be discussed with Executive Director or their | | |
| | | ne blood sugar-45. | | designee at weekly managem | ent | |
| | | - | | meeting for ongoing complian | | |
| | The resident's " | Blood Glucose | | 5) By what date the | l l | |
| | | m" dated April 2014, and | | systemic changes will be | | |
| | _ | ' indicated the following | | completed: Date of complet 7/25/14 | ion: | |
| | | rs lacked documentation | | 1120/14 | | |
| | _ | an was notified. | | | | |
| | 1 | nner blood sugar-63. | | | | |
| | | nner blood sugar-61. | | | | |
| | | C | | | | |
| | 4/20/14Beatir | ne blood sugar-66. | | | | |
| | | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 3 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIP | LE CO | NSTRUCTION | (X3) DATE | |
|--|--------------------------------------|------------------------------|-------------|-------|---|------------|------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | ì | 00 | COMPL | |
| | | | B. WING | | | 06/05/ | 2014 |
| NAME OF F | ROVIDER OR SUPPLIER | 3 | | | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | 96TH ST | | |
| RITTENH | HOUSE SENIOR LIV | VING OF INDIANAPOLIS | INI | DIANA | APOLIS, IN 46260 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAC | 3 | DEFICIENCY) | | DATE |
| | The resident's "F | | | | | | |
| | Monitoring Form" dated May 2014, and | | | | | | |
| | | indicated the following | | | | | |
| | _ | s lacked documentation | | | | | |
| | that the Physicia | | | | | | |
| | | mer blood sugar-67. | | | | | |
| | | mer blood sugar-69. | | | | | |
| | | ner blood sugar-61. | | | | | |
| | | mer blood sugar-61. | | | | | |
| | 5/12/14Pre-dinner blood sugar-64. | | | | | | |
| | 5/18/14Hypoglycemic Reaction blood | | | | | | |
| | sugar-56 at 3:15 | P.M. | | | | | |
| | 5/18/14Hypog | lycemic Reaction blood | | | | | |
| | sugar63 at 8:00 |) P.M. | | | | | |
| | | | | | | | |
| | The resident's M | lay 2014 sliding scale | | | | | |
| | insulin orders la | cked call parameter | | | | | |
| | orders. | | | | | | |
| | | | | | | | |
| | During an interv | riew on 6/5/14 at 3:20 | | | | | |
| | P.M., the Reside | ent Care Director (RCD) | | | | | |
| | indicated the res | ident's sliding scale | | | | | |
| | orders should ha | ve had call parameters. | | | | | |
| | She indicated sh | e would have expected | | | | | |
| | the nurses to not | ify the Physician of a | | | | | |
| | low blood sugar | to get orders from the | | | | | |
| | _ | indicated she considered | | | | | |
| | a low blood suga | | | | | | |
| | | | | | | | |
| | 2. Resident #35 | 's record was reviewed | | | | | |
| | | 05 A.M. Diagnoses | | | | | |
| | | ere not limited to, senile | | | | | |
| | | a, sleep apnea, debility | | | | | |
| | and depressive d | | | | | | |
| | | | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 4 of 47

| | NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | CON | TE SURVEY MPLETED 05/2014 |
|--------------------------|--|--|--|--------|---------------------------------|
| | PROVIDER OR SUPPLIER HOUSE SENIOR LIVING OF INDIANAPOLIS | STREET A 1251 W | ADDRESS, CITY, STATE, ZIP COI 96TH ST APOLIS, IN 46260 | DE . | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| | On 6/3/14 at 10:15 A.M., Resident #35 was observed sitting in his room, facing towards the hallway door, at the end of the Reflections Unit (Dementia Unit) with a mask over his mouth and nose. He was observed receiving a nebulizer treatment (A breathing treatment medication). At 10:22 A.M., the Assistant Resident Care Director (ARCD) came into the resident's room and shut the nebulizer machine off. She took the mask off the resident and placed his glasses on his face, then left the room. The June 2014, Medication Administration Record (MAR) included, but was not limited to the following order: 5/20/14Albuterol 0.083% Inhalation Solution (A breathing treatment medication that helped dilate the lungs to make breathing easier). Inhale 3 ml (milliliters) orally three times daily routinely. Scheduled for 8 A.M., 12 P.M. and 4 P.M. During an interview on 6/4/14 at 1:40 P.M., the Assistant RCD indicated she had given the 12 P.M., nebulizer treatment after 10 A.M., and she had signed it off on the MAR for the 12 P.M., | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 5 of 47

| | NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/05/2014 |
|--------------------------|---|--|---|---------------------------------------|
| | PROVIDER OR SUPPLIER HOUSE SENIOR LIVING OF INDIANAPOLIS | 1251 W | ADDRESS, CITY, STATE, ZIP CODE 96TH ST APOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | dose. She indicated she had given Resident #35 the 12 P.M., nebulizer treatment early due to he was short of breath. She indicated she had not notified the Physician about the resident's shortness of breath on 6/3/14 until this morning when she notified the Physician he "did not look good and required an assist of three to get him out of bed this morning." During an interview on 6/4/14 at 3:20 P.M., the RCD indicated the ARCD should have notified the Physician on 6/3/14 regarding his shortness of breath to get an order to give the scheduled 12 P.M., nebulizer treatment early. During an interview on 6/5/14 at 4:10 P.M., the ARCD indicated she did not document the resident's shortness of breath or called to notify the Physician on 6/3/14 of the resident's change in condition and she should have documented and called. A current policy dated 4/30/2008, provided by the RCD on 6/5/14 at 9:34 A.M., titled "3.7 Observation and Recording" indicated, "Process: 2. All staff is responsible for recording any significant change or problems, either observed or reported by the resident, in | | | |
| | the resident's medical record" | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 6 of 47

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: | ILDING NG | 00 | COMPI 06/05 | LETED |
|--------------------------|--|--|---------------------|--|----------------|----------------------------|
| | | /ING OF INDIANAPOLIS | 1251 W | ADDRESS, CITY, STATE, ZIP CODE 96TH ST APOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | provided by the I A.M., titled "Not Policy-Phylicians Parties" indicated 2.1 Upon report change of condit the resident's cor or psychosocial t significant change resident's physical condition noted. | e, Residents, Responsible d, "Process: Steps: of or observance of a ion immediately assess addition; physical, mental to determine if there is a ge. 2.2 Notify the ian of the change in | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 7 of 47

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMEN | | | | (X3) DATE | | | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | | B. WIN | | | 06/05/ | 2014 |
| | | | D. WIN | | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | | | |
| חודדרגיי | IOLICE CENTOD : " | (INIC OF INIDIANIADOLIO | | | 96TH ST | | |
| KILLENE | IOOSE SENIOR LIV | /ING OF INDIANAPOLIS | | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| R000092 | and disaster prepared continuity of care of emergency as follors (1). Fire exit drills in transmission of a final simulation of emerexcept that the more residents to safe at the building is not conducted quarter familiarize all faciliand emergency acconditions. At leasheld every year. Whether the properties of the pr | It maintain a written fire aredness plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and agency fire conditions, overment of nonambulatory reas or to the exterior of required. Drills shall be aly on each shift to the ty personnel with signals extion required under varied to twelve (12) drills shall be alwhen drills are conducted and 6 a.m., a coded any be used instead of six (6) months, a facility ald the fire and disaster with the local fire ord of all training and drills ed with the names and | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 8 of 47

| | VT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/05/2014 |
|--------------------------|---|---|--|--|---|
| | PROVIDER OR SUPPLIER | I : VING OF INDIANAPOLIS | STREET 1251 V | ADDRESS, CITY, STATE, ZIP CODE V 96TH ST NAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY) | (X5) COMPLETION DATE |
| | the facility failed that they attempt disaster drill in or fire department at This deficiency all 77 residents or Findings included A record review for the last year at 4 P.M. The magnetic department at least that he knew about taken this position before that he wassistant. He incompared that he department at the second review for the last year at 4 P.M. The magnetic documentation is facility had attended at the facility had attended at the facility had or disaster drill in the facility had repartment at the second review assistant. He incompared that he wassistant. He incompared that he wassistant. He incompared that he was defined as a second review for the second review | of the facility's fire drills was reviewed on 6/3/14 | R000092 | R 092 410 IAC 16.2-5-1. 3(i (1-2) Administration and Management 1) What corrective action(s) will be accomplished for those resignated to have been affected the deficient practice: All residents have the potential affected. The facility will document the attempts to he fire and disaster drill in conjunction with the local fire department at least every si months. 2) How the facility identify other residents having potential to be affected by the same deficient practice and corrective action will be take All residents have the potential to be affected. 3) What mea will be put into place or what systemic changes the facility make to ensure that the defi practice does not recur: If facility will document the attention hold a fire and disaster dreconjunction with the local fire department at least every si months 4) How the correct action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be printo place: The facility Maintenance Director or the designee, will review schedular fire drills, where facility has contacted local fire department their attempts to hold a sem annual fire and disaster drill conjunction with the local fire department, at facility's safe | dents by to be old a e x (6) y will ng the ne what en: tial to sures t y will icient he empts fill in e x (6) ctive o e will out ir uled ent in i- s in e |

| | | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED 06/05/2014 |
|--------------------------|---|--|---------------------|---|--------------------------------------|
| NAME OF T | DOLUDED OF CURRY YES | | B. WING STREET | ADDRESS, CITY, STATE, ZIP CODE | 30.00.2011 |
| | PROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | | V 96TH ST NAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| R000093 | 410 IAC 16.2-5-1.3 Administration and Noncompliance (j) If professional of to be provided to the resource, either incarrangement shall the licensee and the provision of the seagreement is used following: (1) the responsibility the outside resource) the qualification staff; (3) a description of provided, including of findings; and (4) the duration of Based on interviation of the facility failed tests were obtain reviewed for labor (Residents #11 at Findings include 1. Resident #11' on 6/5/14 at 1:22 included, but were | I Management - or diagnostic services are the facility by an outside dividual or institutional, an be developed between the outside resource for the rvices. If a written late, it shall specify the ties of both the facility and ce; the outside resource of the outside resource of the type of services to be graction taken and reports the agreement. The wand record review, and to ensure laboratory test results. The form of the type of the services to be graction taken and reports the agreement. I to ensure laboratory the for 2 of 4 residents to be consured to the services to be graction taken and reports the agreement. I to ensure laboratory the form of the f | R000093 | meetings. 5) By what dat the systemic changes will be completed: Date of completed 7/25/14 R 093 410 IAC 16 .2-5-1 .3(i) (1-4) Administration and Management 1) What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice: Labs: Resident #11: Lab orders and results given for this resident for ALT test. Resident #35: Lab orders and results were given this resident for CBC with differential, Hgb A 1C, PSA, T Vitamin D level, B12 level and prealbumin. 2) How the facility will identify other resident having the potential to be affected. | o7/25/2014 onts y for for SH, ents |
| | A Physician orde | er dated 1/23/14, | | by the same deficient practice | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 10 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CO A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 06/05/2014 | |
|--|---|--|--|--|---|---|--|
| | PROVIDER OR SUPPLIER | VING OF INDIANAPOLIS | STREET . 1251 W | ADDRESS, CITY, STATE, ZIP COI V 96TH ST NAPOLIS, IN 46260 | DE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) | ILD BE ROPRIATE CO | (X5) MPLETION DATE | |
| | labs of ALT [Al [A laboratory text disease], TSH [7] Hormone] [A lai measured the thy [and] Lipid paner measured liver for Scheduled Date-The resident's relaboratory result. During an interved P.M., the Reside indicated she has get the results for laboratory test hindicated the laboratory test hindicated the laboratory. 2. Resident #35 on 6/4/14 at 10:0 included, but we diabetes mellitus hyperlipidemia, asthma. A Physician's or indicated CBC (with differential for infection and (complete metal). | cord lacked ALT | | and what corrective action taken: All residents hat potential to be affected. What measures will be public or what systemic control the facility will make to enthat the deficient practice not recur: The facility will implement lab tracking sensure the timely complerequested lab orders. The corrective action(s) will monitored to ensure the practice will not recur, i.e. quality assurance prograput into place: The Recare Director and or their designee will monitor the tracking system daily Monthrough Firday for four (and one (1) time a week thereafter, to ensure the completion of requested orders. The results of the monitoring tool will be disreviewed with the Execur Director or their desgines weekly management me compliance. 5) By what the systemic changes will completed: Date of confidence or the confidence of t | ave the 3) ut into hanges haure does l /stem to stion of 4) How fill be deficient ., what m will be sident r lab haday) weeks timely lab e e at the eting for at date l be | | |

| | | IDENTIFICATION NUMBER: | LDING | 00 | COMPL 06/05/ | ETED |
|--------------------------|--|--|---------------------|--|-----------------|----------------------------|
| | ROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | STREET A | ODDRESS, CITY, STATE, ZIP CODE 96TH ST APOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE |
| | of diabetics), PSA Antigen) (A labor for prostate cancer B12 (Vitamin B1 (A laboratory test malnutrition). The resident's recresults for the CEA1C, PSA, TSH, level and prealburing an intervious A.M., the RCD is contacted the Lal results and the late CBC with different TSH, Vitamin D prealburin were | at checked compliance A (Prostate Specific bratory test that checked er), Vitamin D OH level, (2) level and Prealbumin t that checked for cord lacked laboratory BC with differential, Hgb to Vitamin D level, B12 min. diew on 6/5/14 at 9:10 Indicated she had boratory to get the test boratory tests for the ential, Hgb A1C, PSA, level, B12 level and not drawn when the to but she was having | | | | |
| R000117 | qualifications, and with applicable sta the twenty-four (24 | ency ufficient in number, training in accordance te laws and rules to meet l) hour scheduled and s of the residents and | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 12 of 47

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING OCMPLETED 06/05/2014 NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260 |
|--|
| NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260 |
| NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260 |
| RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS 1251 W 96TH ST INDIANAPOLIS, IN 46260 |
| RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS INDIANAPOLIS, IN 46260 |
| (VA) ID CHMMADY STATEMENT OF DEFICIENCIES ID |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE |
| qualifications, and training of staff shall |
| depend on skills required to provide for the specific needs of the residents. A minimum |
| of one (1) awake staff person, with current |
| CPR and first aid certificates, shall be on |
| site at all times. If fifty (50) or more residents |
| of the facility regularly receive residential |
| nursing services or administration of |
| medication, or both, at least one (1) nursing |
| staff person shall be on site at all times. Residential facilities with over one hundred |
| (100) residents regularly receiving |
| residential nursing services or administration |
| of medication, or both, shall have at least |
| one (1) additional nursing staff person |
| awake and on duty at all times for every |
| additional fifty (50) residents. Personnel |
| shall be assigned only those duties for which |
| they are trained to perform. Employee duties shall conform with written job descriptions. |
| Based on record review and interview the R000117 R 117 410 IAC 16.2-5-1.4(b) 07/25/2014 |
| facility failed to ensure there was a CPR Personnel 1) What corrective |
| action(s) will be accomplished for |
| (cardiopulmonary resuscitation) and first those residents found to have |
| aid certified staff member in the facility been affected by the deficient |
| available for residents at all times. This practice: All residents have the |
| had the potential to affect all 77 residents potential to be affected. The facility completed CPR and First |
| currently living in the facility. aid training on 6/17/14, to ensure |
| that employees have received |
| Findings include: CPR/ First aid training. 2) |
| How the facility will identify other |
| Record review of employee records was residents having the potential to |
| be affected by the same deficient |
| completed on 6/3/2014 at 3:20 P.M. The practice and what corrective action will be taken: All |
| certifications were reviewed. certifications were reviewed. residents have the potential to be |
| affected. 3). What measures |
| will be put into place or what |
| The record for the Nursing and CNA systemic changes the facility will |
| (Certified Nursing Assistant) schedule as make to ensure that the deficient |
| worked for the past week was provided practice does not recur: The |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 13 of 47

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | 00 | COMI | e survey pleted 5/2014 |
|--------------------------|---|---|---------------------|--|--|------------------------------|
| | PROVIDER OR SUPPLIER | I VING OF INDIANAPOLIS | 1251 W | ADDRESS, CITY, STATE, ZIP CO / 96TH ST IAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY) | RECTION OULD BE PPROPRIATE | (X5) COMPLETION DATE |
| | The two records following was for On 5/31/14 for the shift no staff had Aid certification On 5/31/14 for the shift no staff had certification. On 6/1/14 for the no staff had curricertification. On 6/1/14 for the shift no staff had curricertification. On 6/3/14 for the shift no staff had Aid certification On 6/3/14 for the shift no staff had Aid certification. In an interview with the shift no staff had a certification. In an interview with the shift no staff had a certification. | were compared and the bund: he 2 P.M. to 10 P.M., I current CPR and First he 10 P.M. to 6 A.M., I current CPR and First he 2 P.M. to 10 P.M., shift ent CPR and First Aid he 10 P.M. to 6 A.M., I current CPR and First he 10 P.M. to 6 A.M., I current CPR and First he 10 P.M. to 6 A.M., I current CPR and First he 10 P.M. to 6 A.M., I current CPR and First he 11 P.M. to 6 A.M., I current CPR and First he 12 P.M., she indicated the he First Aid certifications he 12 P.M., she indicated the he 13 First Aid certifications he 14 First Aid certifications | | facility will ensure at lead current nursing staff, or shift, will have completed and first aid training prise scheduling duties. The corrective action(s) monitored to ensure the practice will not recur, i quality assurance progrupt into place: The factive will monthly massischedule and the currefirst aid completed train licensed staff, schedule to ensure compliance. I review will be discussed Executive Director or the designee, at weekly massing meeting for compliance By what date the system changes will be completed to complete of completion: 7/2 | n each ed CPR or to 4) How will be e deficient e.e., what ram will be ility will ster nt CPR/ ning of all ed to work, Results of d with neir anagement e. 5) mic eted: | |
| R000119 | Personnel - Nonco (d) Prior to workin employee shall be facility by the supe | 4(d)(1)(A-E)(2)(A-D)(3- ompliance g independently, each given an orientation to the ervisor (or his or her epartment in which the | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 14 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|--|--|---|------------------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | | A. BUILDING B. WING | | 06/05/2014 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> |
| NAME OF P | PROVIDER OR SUPPLIER | t | | / 96TH ST | |
| RITTENH | OUSE SENIOR LIV | VING OF INDIANAPOLIS | | IAPOLIS, IN 46260 | |
| | | | | 171 0210, 114 40200 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | ' ' | k. Orientation of all | | | |
| | | nclude the following: | | | |
| | (1) Instructions on | | | | |
| | specialized popula (A) aged; | auons. | | | |
| | (B) developmental | lly disabled: | | | |
| | (C) mentally ill; | , | | | |
| | (D) dementia; or | | | | |
| | (E) children; | | | | |
| | served in the facili | | | | |
| | * * | e facility's policy manual | | | |
| | | ocedures, including: | | | |
| | (A) organization cl | | | | |
| | (B) personnel poli | cies; nd grooming policies for | | | |
| | employees; and | nd grooming policies for | | | |
| | (D) residents' right | ts | | | |
| | ` ' | rst aid, emergency | | | |
| | procedures, and fi | | | | |
| | preparedness, inc | | | | |
| | procedures. | | | | |
| | ` ' | cal considerations and | | | |
| | | esident care and records. | | | |
| | (5) For direct care | | | | |
| | | d instruction in, the | | | |
| | · • | f each resident to whom | | | |
| | | be providing care. n of the orientation in the | | | |
| | | nnel record by the person | | | |
| | supervising the or | | | | |
| | | review and interview the | R000119 | R 119 410 IAC 16.2-55-1. 4(d | 07/25/2014 |
| | | instruct each employee | | (A-E)(2)(A-D)(3-) Personnel | 1) |
| | 1 | | | What corrective action(s) will | |
| | in orientation of dementia care. This deficiency had the potential to affect 22 residents in the secured dementia unit and | | | accomplished for those reside | |
| | | | | found to have been affected b | у |
| | | | | the deficient practice: All | , h - |
| | any of the 55 res | sidents in the un-secured | | residents have the potential to | o be |
| | area showing sig | gns of dementia residing | | affected. The facility will have staff with completed dementia | |
| | in the facility. | | | training caring for residents in | |
| | | | | secured area and unsecured | |
| | Findings include | • | | of the facility. 2) How the fa | |
| | i mamga merade | ·• | | , , , | · |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 06/05/2014 | |
|--|--|---|---------------------|---|--|
| | ROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | STREET A 1251 W | ADDRESS, CITY, STATE, ZIP CODE / 96TH ST JAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | DATE |
| | completed on 6/5 record was reviet training for 8 ememployees had done was the MC Director) and the (Director of Dinector) and interview was 6/5/14 at 3:20 P. dementia training and just recently | with the Administrator on M., she indicated g had been very sporadic they started doing the focus on the staff in the | | will identify other residents have the potential to be affected by same deficient practice and was corrective action will be taken All residents have the potential be affected. 3). What measures will be put into play what systemic changes the fawill make to ensure that the deficient practice does not reactive that the deficient practice does not reactive action (will receive or have documented evidence of receiving dementia training. 4) How the corrective action (will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place The facility will review at well management meeting with executive Director or their designee, the staff listing with current dementia training completed, to ensure staff have received dementia training to ensure compliance. 5) Be what date the systemic change will be completed: Date of completion: 7/25/14 | y the what his |
| R000148 | (e) The facility sha grounds, and equi condition, in good that may adversel welfare of the resi follows: (1) Each facility sh implement a writte | fety Standards - Deficiency all maintain buildings, pment in a clean repair, and free of hazards y affect the health and dents or the public as all establish and | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 16 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|---|----------------------------|----------|---|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPI | |
| | | | B. WING | | | | /2014 |
| NAME OF | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| NAME OF | PROVIDER OR SUPPLIEF | C | | 1251 W | / 96TH ST | | |
| RITTENI | HOUSE SENIOR LI | VING OF INDIANAPOLIS | | INDIAN | IAPOLIS, IN 46260 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | sources, fire alamshall be maintaine functioning and conclectrical codes. (3) All plumbing sincomply with state (4) At least yearly systems shall be in Based on observing record review, the heating and inspected annual laundry dryer limits deficiency all 77 residents in Findings included 1. A record review for the following included by the 6/4/14 at 12:19 in the maintain of the performed on 11 conditioning uning the following in the following an interview in the heating and into the been inspected. | system, including a switches, alternate power of and detection systems, and to guarantee safe compliance with state of the property and plumbing codes. The property and plumbing codes. The property and plumbing and ventilating inspected. The property and the facility failed to have eventilating systems and the facility failed to have eventilating systems and the potential to affect residing in the facility. The property and the potential to affect residing in the facility. The property and the potential to affect residing in the facility. The property and the potential to affect residing in the facility. The property and the property and the potential to affect residing in the facility. The property and the property and the property and the potential to affect residing in the facility. | R00 | 00148 | R148 410 IAC 16.2-55(e) (19 Sanitation and Safety 1) What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice: A. The facility will contract with a qualified outside provider to annually inspect the heating a ventilation systems. All reside have the potential to be affect B. Lint filters in dryers were immediately cleaned. Staff in serviced on compliance with cleaning lint filters. All residen have the potential to be affect 2) How the facility will ide other residents having the potential to be affected by the same deficient practice and w corrective action will be taken All residents have the potentia be affected. 3) What measu will be put into place or what systemic changes the facility of make to ensure that the defici practice does not recur: A. The heating and ventilation system will be inspected annually as indicated on the service agreement with the qualified | be ents by e and nts ed. ts ed. ntify that : all to ures will ent The | 07/25/2014 |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 17 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CO | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|--|--|---|-------------------------|---|--|
| | 2. 2014 | | A. BUILDING B. WING | | 06/05/2014 |
| NAME OF F | PROVIDER OR SUPPLIEF HOUSE SENIOR LI' SUMMARY S (EACH DEFICIEN REGULATORY OR | VING OF INDIANAPOLIS TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) Tained to inspect the | B. WING STREET A 1251 W | ADDRESS, CITY, STATE, ZIP CODE / 96TH ST IAPOLIS, IN 46260 PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) outside provider. B. Maintenance and or their designee will check dryers | 06/05/2014 (X5) COMPLETION DATE |
| | 2. During the environmental tour on 6/4/14 at 11:20 A.M., with the Maintenance Director in attendance, the main laundry room right sided dryer was observed to have had resident's clothes sitting in it. The lint filter under the dryer drum was observed covered with white lint. The Maintenance Director used his right hand and wiped his four fingers across the lint filter and had lint balled up on his fingers. The area of the filter that he had wiped was clean. The left side of the dryer was observed to have had a load of towels that were being dried. On 6/5/14 at 9:50 A.M., with the | | | Monday through Friday for (4) weeks and one (1) time week thereafter, for compl with the cleaning of lint filte 4) How the corrective action will be monitored to ensure deficient practice will not reive, what quality assurance program will be put into plate. The Executive Director review the annual inspection the heating and ventilation systems for compliance are report results of review at Safety Meeting. B. The Executive Director or their designee will review the monitoring tool for daily drected cleaning checks at weekly management meeting for compliance. 5) By what | e a iance ers. on(s) e the ecur, e ace: will on of ad facility's |
| | laundry room, be with the lint filter covered with who During an interval A.M., the Maint the lint filter was every load of lau CNA's signed a cleaned the filter cleaned. A document han | attendance both main oth dryers were observed ers under the dryer drum nite lint. Tiew on 6/4/14 at 11:20 enance Director indicated is to be cleaned "after" andry. He indicated the sheet of paper when they is to indicate it had been eging on a clipboard by yer titled, "Yes I cleaned" | | the systemic changes will completed: Date of com 7/25/14 | be |

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PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---------------------|--------------------------------|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | | B. WING | | 06/05/2014 |
| NAMEOUS | DD OLUDED OF GUREY | D. | | ADDRESS, CITY, STATE, ZIP CODE | 1 |
| NAME OF I | PROVIDER OR SUPPLIE | К | | V 96TH ST | |
| RITTEN | HOUSE SENIOR L | IVING OF INDIANAPOLIS | INDIAN | NAPOLIS, IN 46260 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| TAG | 1 | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCE | DATE |
| | | the Dryer" indicated | | | |
| | | ite you cleaned lint filter, | | | |
| | | e you put in a load to | | | |
| | 1 | ment was signed with a | | | |
| | 1 - | ese lines for the date of 6/2 | | | |
| | | o 2 P.M. shift and 6/3 for | | | |
| | | P.M. The document had | | | |
| | no other signatu | ares at this time. | | | |
| | During an inter- | view on 6/4/14 at 5:10 | | | |
| | _ | nistrator indicated the 2 | | | |
| | 1 | ., shift CNA's gathered | | | |
| | | 10 P.M. to 6 A.M., shift | | | |
| | 1 | aundry and the 6 A.M. to | | | |
| | | NA's delivered the | | | |
| | · · | dicated all shifts did the | | | |
| | | ed if resident's had | | | |
| | incontinent epis | | | | |
| | incontinent epis | odes. | | | |
| | During an inter- | view on 6/5/14 at 9:50 | | | |
| | A.M., the Admi | inistrator indicated both | | | |
| | • | y room dryer lint filters | | | |
| | | eaned. She indicated | | | |
| | | d back at the April 2014 | | | |
| | | lint filter documentation | | | |
| | _ | ings and midnights have | | | |
| | | g the forms, which could | | | |
| | | ers were not cleaned | | | |
| | | Flaundry was placed into | | | |
| | | raunury was praceu ilito | | | |
| | the dryer. | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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| AND PLAN | OF CORRECTION PROVIDER OR SUPPLIER HOUSE SENIOR LIV | IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VING OF INDIANAPOLIS TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL | A. BUILI B. WING | STREET A | ADDRESS, CITY, STATE, ZIP CODE / 96TH ST APOLIS, IN 46260 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X3) DATE COMPL 06/05 | ETED |
|----------|---|--|---------------------|----------|--|--|------------|
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | IE | DATE |
| R000154 | (k) The facility shakitchen areas, conequipment, and ut litter and rubbish, repair in accordan Based on observed record review, the maintain a clean label food items deficiency had the transfer of the kitchen Findings include On 6/3/14 at 9:3 safety tour of the FSA (Food Servattendance. He is the cooks. During the initiate observed packed the door. On the number of bagger plastic bags. So faded and hard to label indicating on the top shely looked to be wafel | fety Standards - Deficiency all keep all kitchens, anmon dining areas, aensils clean, free from and maintained in good ce with 410 IAC 7-24. ation, interview and ae facility failed to freezer, and oven and to in the freezer. This ae potential to affect all aently receiving food | R000 | 0154 | R154 410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards 1) What corrective action(s) will be accomplished for those reside found to have been affected b the deficient practice: A.T Dietary staff removed all unlabeled and undated food it that were identified during the survey. All residents have the potential to be affected. B.T inside of oven and freezer wer cleaned during survey. All residents have the potential to affected. 2) How the facil will identify other residents hav the potential to be affected by same deficient practice and wi corrective action will be taken: All residents have the potentia be affected. 3) What measu will be put into place or what systemic changes the facility w make to ensure that the deficie practice does not recur: A. Dietary staff was re- in-service on Labeling Policy. B. Dietar staff was re-in-serviced on compliance with cleaning schedule and Monitoring kitch sanitation. 4) How the | y he he ems The the the ity ving the hat il to ires vill ent ed | 07/25/2014 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
|--|----------------------|-----------------------------------|-----------------|---|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | |
| | | | B. WING | | 06/05/2014 | |
| | | <u> </u> | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | V 96TH ST | | |
| | | /ING OF INDIANAPOLIS | | NAPOLIS, IN 46260 | | |
| (X4) ID | | SUMMARY STATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | were not dated o | r labeled in any way. On | | corrective action(s) will be | | |
| | one of the middl | e shelves a bottle of what | | monitored to ensure the defici practice will not recur, i.e., wh | | |
| | was observed to | be dark frozen soda pop | | quality assurance program wil | | |
| | was on the shelv | e. There was also a | | put into place: A. Dietary | | |
| | naner like bag ol | oserved with food items | | Services manager and or thei | r | |
| | | . No identification of the | | designee will do daily audits | | |
| | _ | ate was observed on the | | Monday through Friday for for | ır | |
| | | lip of the freezer was | | (4) weeks and one (1) time a week thereafter. The consulta | ant | |
| | observed with fo | _ | | RD will do every other month | מווג | |
| | ooserved with 10 | ou residue. | | audits of compliance (ongoing | per | |
| | To an interior | | | contract) with food labeling | | |
| | | vith FSA #1, at this time, | | policy. B. The Dietary Serv | | |
| | | e took one of the bags | | Manager and or their designe | e | |
| | out, that it looke | d to him like it was most | | will review the results of their | | |
| | likely containing | chicken fingers. The | | audit with Executive Director of their designee at weekly | or | |
| | food item sticking | g out of the paper bag he | | management meeting for | | |
| | identified as swe | et potato fries. He had | | compliance. 5) By what dat | e | |
| | no explanation for | or the frozen soda pop or | | the systemic changes will be | | |
| | the general cond | ition of the freezer. | | completed: Date of complete | tion: | |
| | - | | | 7/25/14 | | |
| | | f the facility's labeling | | | | |
| | | ucted on 6/4/14 at 3:25 | | | | |
| | P.M., of the facil | lity's record titled: "Date | | | | |
| | Marking." The r | record indicated, | | | | |
| | "Expiration date | s: Is the date with which | | | | |
| | the manufacture | guarantees the food will | | | | |
| | | standards. Date marking | | | | |
| | | res the safety of the | | | | |
| | food" | | | | | |
| | | | | | | |
| | On 6/3/14 at 9·4 | 5 A.M., during the | | | | |
| | | fety tour of the kitchen, | | | | |
| | | oven door was observed | | | | |
| | | due covering part of it. | | | | |
| | io nave 1000 fest | due covering part of it. | | | | |
| | | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 21 of 47

| | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/05/2014 |
|--|---|--|---|--|
| | | B. WING | | 00/03/2014 |
| | | 1251 W | V 96TH ST | |
| (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| (Director of Dini 3:30 P.M., she in not be next to the be labeled. She was in need of cl suppose to be wi cleaned once per | ng Services) on 6/4/14 at adicated waffles should a meat and items should indicated the freezer eaning. The oven is ped daily and deep month. | | | |
| Evaluation - Defici (a) An evaluation of each resident shat admission and shat semiannually and change in the reside A licensed nurse is needs of the reside Based on intervi- the facility failed individual needs significant changupdated Service reviewed for Ser #9, #11, #35, #59 and Findings include 1. Resident #11' on 6/5/14 at 1:22 | ency of the individual needs of I be initiated prior to all be updated at least upon a known substantial dent's condition, or more nt's or facility's request. shall evaluate the nursing ent. ew and record review, I to evaluate the of residents related to ges in conditions and Plans for 5 of 8 residents vice Plans . (Residents d #96) : s record was reviewed P.M. Diagnoses | R000214 | R214 410 IAC 16.2-5-2(a) Evaluation 1) What correaction(s) will be accomplished those residents found to have been affected by the deficie practice: Service Plans for: Resident #11: Service plan updated to reflect significant change in current resident condition. Resident #35 Seplan updated to reflect significant change in current resident condition. Resident# 59 Seplan updated to reflect significant change in current resident condition. Resident# 59 Seplan updated to reflect significant change in current resident condition. 2) How the facility of the sidness that the sidness | ed for ve nt t rvice ficant rvice ficant |
| | ROVIDER OR SUPPLIER ROUSE SENIOR LIVE SUMMARY STREGULATORY OR During an interver (Director of Dining 3:30 P.M., she in not be next to the be labeled. She was in need of classification of the suppose to be with cleaned once per suppose to be with | ROVIDER OR SUPPLIER ROUSE SENIOR LIVING OF INDIANAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) During an interview with the DDS (Director of Dining Services) on 6/4/14 at 3:30 P.M., she indicated waffles should not be next to the meat and items should be labeled. She indicated the freezer was in need of cleaning. The oven is suppose to be wiped daily and deep cleaned once per month. 410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident's condition, or more often at the resident's or facility's request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate the individual needs of residents related to significant changes in conditions and updated Service Plans for 5 of 8 residents reviewed for Service Plans . (Residents | ROVIDER OR SUPPLIER ROUSE SENIOR LIVING OF INDIANAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) During an interview with the DDS (Director of Dining Services) on 6/4/14 at 3:30 P.M., she indicated waffles should not be next to the meat and items should be labeled. She indicated the freezer was in need of cleaning. The oven is suppose to be wiped daily and deep cleaned once per month. 410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident 's or facility 's request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate the individual needs of residents related to significant changes in conditions and updated Service Plans for 5 of 8 residents reviewed for Service Plans . (Residents #9, #11, #35, #59 and #96) Findings include: 1. Resident #11's record was reviewed on 6/5/14 at 1:22 P.M. Diagnoses | ROVIDER OR SUPPLIER ROUSE SENIOR LIVING OF INDIANAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) During an interview with the DDS (Director of Dining Services) on 6/4/14 at 3:30 P.M., she indicated waffles should be labeled. She indicated the freezer was in need of cleaning. The oven is suppose to be wiped daily and deep cleaned once per month. 410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident' s or facility 's request. A licensed nurse shall evaluate the nursing needs of the resident condition, and updated Service Plans for 5 of 8 residents reviewed for Service Plans (Residents #9, #11, #35, #59 and #96) Findings include: 1. Resident #11's record was reviewed on 6/5/14 at 1:22 P.M. Diagnoses |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 22 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MUL | TIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY | |
|--|----------------------|------------------------------|--|------------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | V DIMIP | NNC | 00 | COMPL | ETED |
| | | | A. BUILD | ING | | 06/05/ | 2014 |
| | | | B. WING | CTDEET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | | | |
| DITTE: " | IOLIGE OFFICE : " | AVINIO OF INDIANA DOLLO | | | 96TH ST | | |
| KII I ENF | 1002F 2FNIOK FI | VING OF INDIANAPOLIS | [| INDIAN/ | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | II, depression an | nd anxiety. | | | the potential to be affected by | | |
| | - | | | | same deficient practice and wl | | |
| | The resident's cu | ırrent "Six Month Care | | | corrective action will be taken: | | |
| | | | | | All residents have the potentia | l to | |
| | Plan Review" da | - | | | be affected. 3) What measures will be put into place | o or | |
| | | ea indicated, the resident | | | what systemic changes the fac | | |
| | | f bowel and bladder. The | | | will make to ensure that the | Jiii Ly | |
| | "Physical Health | n" area indicated the | | | deficient practice does not rec | ur: | |
| | resident's blood | sugars fluctuated and she | | | The Service Plans for all | | |
| | was non-complia | ant with her diet | | | residents shall be audited to | | |
| | frequently. | | | | ensure the Service Plan | | |
| | irequentry. | | | | addresses resident needs, | | |
| | T1 | Manual, Carra Dlan | | | preferences, current physician | | |
| | | Month Care Plan | | | orders, specific medical | | |
| | | documentation of the | | | requirements and significant | 4) | |
| | resident's signifi | cant change of | | | changes in condition. | 4) | |
| | conditions. The | resident had been treated | | | How the corrective action(s) w be monitored to ensure the | 111 | |
| | with antibiotics | for a urinary tract | | | deficient practice will not recur | | |
| | | h abscess and had a tooth | | | i.e., what quality assurance | , | |
| | extraction since | | | | program will be put into place: | | |
| | CATACTION SINCE | 1/20/17. | | | The Service Plans for all | | |
| | | | | | residents shall be audited by the | he | |
| | _ | view on 6/5/14 at 3:20 | | | Resident Care Director and or | | |
| | P.M., the Reside | ent Care Director (RCD) | | | their designee, daily Monday | | |
| | indicated she had | d not updated the | | | through Friday for four (4) wee | eks | |
| | resident's "Servi | ce Plan" or completed | | | and one (1) time a week | | |
| | | for the resident's urinary | | | thereafter, to ensure the Serv | | |
| | | ooth abscess or tooth | | | Plan addresses resident needs preferences, current physician | | |
| | • | ooth tooth | | | orders, specific medical | | |
| | extraction. | | | | requirements and significant | | |
| | | | | | changes in condition. Review | v of | |
| | | 's record was reviewed | | | the twenty-four hour report | | |
| | on 6/4/14 at 10:0 | 05 A.M. Diagnoses | | | (change in condition) and new | | |
| | included, but we | ere not limited to, senile | | | orders will be used to update i | | |
| | dementia, asthm | a, sleep apnea, chronic | | | appropriate the current resider | | |
| | · · | disorder and debility. | | | service plan. Results of the au | | |
| | pain, acpiessive | and deciming. | | | will be discussed with Executive | /e | |
| | TT1 | mand IIC: Mand C | | | Director or their designee at | to | |
| | i ne resident's cu | arrent "Six Month Care | | | weekly management meeting | ເບ | |

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULT | TPLE CO | NSTRUCTION | (X3) DATE | | |
|--|--|--------------------------------------|--|------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | 00 | COMPL | ETED |
| | | | B. WING | | | 06/05/ | 2014 |
| | | | | TREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | 96TH ST | | |
| RITTENH | HOUSE SENIOR LI | VING OF INDIANAPOLIS | | | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARVS | SUMMARY STATEMENT OF DEFICIENCIES ID | | | (X5) | | |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD PROVIDER'S PLAN OF CORRECTIVE PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROV | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | AG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | Plan Review" da | ated 10/2/13, indicated | | | ensure compliance. | 5) | |
| | | - | | | By what date the systemic | , | |
| | the resident's "Nutritional Status" area indicated the resident was on a regular | | changes will be completed: | | | | |
| | | • | | | Date of Completion: 7/25/14 | | |
| | diet. The "Medi | | | | | | |
| | | Pain Control" area | | | | | |
| | | s not currently on routine | | | | | |
| | medications. Th | ne "Physical Health" area | | | | | |
| | indicated the res | ident's health was | | | | | |
| | currently stable. | | | | | | |
| | | | | | | | |
| | The resident's cu | ırrent "Six Month Care | | | | | |
| | | cked documentation of | | | | | |
| | | ges. The resident was | | | | | |
| | ` | | | | | | |
| | | reated for a cough with | | | | | |
| | audible wheezin | _ | | | | | |
| | | he had a 9 pound weight | | | | | |
| | loss in February | 2014. | | | | | |
| | Daning on intern | .; on C/A/1A at 1.40 | | | | | |
| | | riew on 6/4/14 at 1:40 | | | | | |
| | · | ndicated she should have | | | | | |
| | l - | ent's significant changes | | | | | |
| | related to his we | eight loss and the cough | | | | | |
| | being treated wi | th nebulizer treatments | | | | | |
| | on the "Service l | Plan". | | | | | |
| | | | | | | | |
| | | 's record was reviewed | | | | | |
| | on 6/4/14 at 12:1 | 13 P.M. Diagnoses | | | | | |
| | included, but we | ere not limited to | | | | | |
| | dementia, atrial | fibrillation osteoporosis, | | | | | |
| | | nsion, and mitral | | | | | |
| | regurgitation. | , | | | | | |
| | | | | | | | |
| | The resident's cu | ırrent "Six Month Care | | | | | |
| | Plan Review" da | ated 5/20/14, indicated | | | | | |
| | Ī | * | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 24 of 47

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CC | ONSTRUCTION 00 | (X3) DATE COMP | E SURVEY LETED | | |
|---|---------------------------------------|---|------------------|---|-------------------------|------------|--|
| | | | A. BUILDING | | | 06/05/2014 | |
| | | | B. WING STREET A | ADDRESS, CITY, STATE, ZIP C | | | |
| NAME OF F | PROVIDER OR SUPPLIER | R | | 96TH ST | · - - | | |
| RITTENH | OUSE SENIOR LI | VING OF INDIANAPOLIS | INDIAN | APOLIS, IN 46260 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COR | RRECTION | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE APPROPRIATE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) /Administration/Pain | TAG | DEFICIENCT | | DATE | |
| | Control" area inc | | | | | | |
| | | her medications, and | | | | | |
| | | od Patterns" indicated | | | | | |
| | | nxiety medication) | | | | | |
| | , | (An antipsychotic | | | | | |
| | medication)-onc | , , , | | | | | |
| | , , , , , , , , , , , , , , , , , , , | medication)-once and | | | | | |
| | Lexapro (An ant | i-depressant)-once. The | | | | | |
| | _ | " area indicated the | | | | | |
| | resident's oxygen saturation after | | | | | | |
| | ambulating 200 feet will be 80% and | | | | | | |
| | | he wheelchair will be | | | | | |
| | 90%. | | | | | | |
| | The resident's cu | urrent "Six Month Care | | | | | |
| | | ated 5/20/14, lacked | | | | | |
| | | of significant changes. | | | | | |
| | The resident was | s sent to the Emergency | | | | | |
| | Room for a large | e laceration to her left | | | | | |
| | | s self inflicted, then she | | | | | |
| | | the Psychiatric unit due | | | | | |
| | _ | elf. The resident had a | | | | | |
| | | d 5/12/14, that indicated | | | | | |
| | | y infiltrate (possible start | | | | | |
| | | n the right lung base. | | | | | |
| | • | aced on Clindamycin (An | | | | | |
| | | ation), oxygen at 2 liters a, mechanical soft diet, | | | | | |
| | | rapy for dysphagia on | | | | | |
| | 5/13/14. | apy 101 uyspnagia 011 | | | | | |
| | J/1J/17. | | | | | | |
| | During an interv | iew on 6/4/14 at 3:20 | | | | | |
| | _ | ndicated she should have | | | | | |
| | | | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 25 of 47

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: | A. BUILDING B. WING | 00 | COMPLETED 06/05/2014 | |
|--------------------------|---|---|---------------------|--|----------------------|--|
| | PROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | 1251 | T ADDRESS, CITY, STATE, ZIP CODE W 96TH ST NAPOLIS, IN 46260 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE | |
| | _ | lent's "Service Plan" with nanges of conditions. | | | | |
| | on 6/5/14 at 10:0 included, but we | s record was reviewed 0 A.M. Diagnoses re not limited to, anxiety ive disorder, dementia, | | | | |
| | Plan Review" up the "Cognitive Pa the resident was The "Behavioral, indicated the resi would ask questi redirected, had m staff intervention staff and utilized bracelet with a be | dent was forgetful and ons repetitively, easily nore anxiety, took a lot of as and redirections from a wanderguard (a ox on it that prevents the | | | | |
| | facility without s "Other" area indi wanderguard tag | ndering out of the taff knowledge). The cated the resident had a due to she was at high nt (exiting the facility owledge). | | | | |
| | Plan Review" up documentation o The resident was confusion, wands behaviors. She h | rrent "Six Month Care dated 8/1/13 lacked f significant changes. being monitored for ering, and unusual and been on 15 minute necks for her safety. She | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 26 of 47

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | | TE SURVEY | |
|---|--|--------------------------------|-------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | | IPLETED |
| | | | B. WING | | 06/0 | 05/2014 |
| NAME OF I | PROVIDER OR SUPPLIEI | R | | ADDRESS, CITY, STATE, ZIP (| CODE | |
| | | | | 96TH ST | | |
| RITTENH | HOUSE SENIOR LI | VING OF INDIANAPOLIS | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COI | | (X5) |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE |
| | | eking at the front door | | | | |
| | | o the employee door exit | | | | |
| | | for her either her car, | | | | |
| | - | or son. She was treated | | | | |
| | · ` | An antibiotic medication) | | | | |
| | 1 | ng on 2/4/14 for a urinary | | | | |
| | | and she had been treated | | | | |
| | | t for behavioral health | | | | |
| | | treated for a urinary tract | | | | |
| | | eptra (An antibiotic | | | | |
| | medication) for 7 days starting 4/24/14. | | | | | |
| | | | | | | |
| | During an interv | view on 6/5/14 at 3:20 | | | | |
| | P.M., the RCD i | indicated the resident's | | | | |
| | "Service Plan" s | should have been updated | | | | |
| | with the signific | ant changes. | | | | |
| | | | | | | |
| | A current policy | dated 1/1/2010, | | | | |
| | provided by the | Administrator on 6/5/14 | | | | |
| | at 10:50 A.M., t | itled "Care Plan and | | | | |
| | Service Plan Gu | idelines for Care 1.1" | | | | |
| | indicated, "Care | Plan 1.0: 1.1 An | | | | |
| | evaluation of the | e individual needs of each | | | | |
| | resident shall be | initiated prior to | | | | |
| | admission and s | hall be updated at least | | | | |
| | | pon a known substantial | | | | |
| | | sident's condition, upon | | | | |
| | _ | ity request"5. Resident | | | | |
| | | reviewed on 6/3/2014 at | | | | |
| | 3 P.M. Diagnos | ses included, but were not | | | | |
| | 1 | y of pelvic fracture, | | | | |
| | l ' | s/ulna fracture (wrist | | | | |
| | <u>-</u> | tosis, depression, | | | | |
| | , · | and history of UTI | | | | |
| | | | | | | 1 |

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PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: | A. BUILDING B. WING | | 00 | COMPLETED 06/05/2014 | |
|--------------------------|---|--|---------------------|------|--|----------------------|----------------------------|
| | ROVIDER OR SUPPLIER | ING OF INDIANAPOLIS | 12 | 51 W | DDRESS, CITY, STATE, ZIP CODE 96TH ST APOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Pection | ID PREF TA | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓΕ | (X5) COMPLETION DATE |
| | completed on 10/ one was completed. The resident's recovered recov | rsing assessment was /23/2013 and another ed on 4/1/14. Ford titled "Six Month v" and dated 11/22/13 attive Patterns alert, nmunication Ability | | | | | |
| | Administrator on they indicated the what their "sister service plans to u at this time they j Review" as their, | dated 1/27/14 at 1 | | | | | |
| | | ent] found on floor in tting position [symbol l for no] pain, a | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 28 of 47

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/05/2014 |
|--------------------------|--|---|--|--|---------------------------------------|
| | ROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | STREET A 1251 W | ADDRESS, CITY, STATE, ZIP CODE / 96TH ST APOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | finger the whole | nbol for left] middle width of knuckle. Order mergency Room] for" | | | |
| | P.M., indicated," being admitted [s | s dated 1/27/14 at 8 notifiedresident is symbol for with] x [fracture], fx wrist and | | | |
| | Plan" after the re At exit on 6/5/14 | d an updated, "Service sident's hospitalization. at 6:20 P.M., no further provided by the facility. | | | |
| R000241 | the provision of res be as ordered by t and shall be super on the premises or (1) Medication sha | | | | |
| | Based on observation record review, the supervise a media a nebulizer treatment. | ation, interview and e facility failed to cation administration of ment for 1 of 7 residents and a nebulizer treatment. | R000241 | R 241 410 IAC 16.2-5-4 (e) (1 Health Services 1) What corrective action(s) will be accomplished for those reside found to have been affected b the deficient practice: Supervi during Medication Administrat Nebulizer for: Resident #35 supervised during his medicat | ents y sion ion/ : Is |
| | Findings include | : | | administration/ Nebulizer Treatment. Licensed nurse, | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 29 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | EY |
|--|--|------------------------------|---|--------|--|-----------------|----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDING | 00 | COMPLETED | |
| | | | B. WIN | | | 06/05/2014 | |
| | | | p. ,, 11, | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | 96TH ST | | |
| RITTENH | HOUSE SENIOR LIV | VING OF INDIANAPOLIS | | | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COM | 1PLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | On 6/3/14 at 10: | 15 A.M., Resident #35 | | | identified during survey, was | | |
| | was observed sit | ting in his room, facing | | | educated on the policy for | | |
| | towards the hally | way door, at the end of | | | Nebulizer treatments. 2) Ho | w | |
| | | Unit (Dementia Unit) | | | the facility will identify other residents having the potential | to I | |
| | | r his mouth and nose. | | | be affected by the same defici | | |
| | | d receiving a nebulizer | | | practice and what corrective | | |
| | | eathing treatment | | | action will be taken: All | | |
| | ` | • | | | residents have the potential to | | |
| | / / | hout any observed staff | | | affected. 3) What measure | es | |
| | | dance. He had his right | | | will be put into place or what systemic changes the facility v | _{/ill} | |
| | hand on the mask at the nose area. At 10:22 A.M., the Assistant Resident Care Director (ARCD) came into the | | | | make to ensure that the deficie | | |
| | | | | | practice does not recur: | | |
| | | | | | Licensed nursing staff was | | |
| | | | | | educated the policy and | | |
| | resident's room a | and shut the nebulizer | | | procedure for Nebulizer | | |
| | machine off. Sh | e took the mask off the | | | Treatments. 4) How the corrective action(s) will be | • | |
| | resident and place | ced his glasses on his | | | monitored to ensure the deficie | ent | |
| | face, then left the | _ | | | practice will not recur, i.e., wha | | |
| | , | | | | quality assurance program will | | |
| | At 10:25 A.M. 1 | the ARCD came back | | | put into place: The Resident C | are | |
| | | 's room and transported | | | Director or their designee will | | |
| | | vity room to join an | | | complete an observation report weekly for four (4) weeks and | | |
| | | vity room to join an | | | (1) time a month thereafter. Th | | |
| | activity. | | | | result of this observation repor | | |
| | | | | | for the performance of the | | |
| | | cord was reviewed on | | | medication administration police | су | |
| | 6/4/14 at 10:05 A | • | | | (nebulizer treatments) will be | | |
| | - | ere not limited to, senile | | | discussed with the Executive Director or their designee, duri | na | |
| | dementia, asthm | a, sleep apnea, debility | | | weekly management meeting | - | |
| | and depressive d | lisorder. | | | | 5) | |
| | | | | | By what date the systemic | | |
| | The June 2014, 1 | Medication | | | changes will be completed: | | |
| | Administration Record (MAR) included, | | | | Date of Completion: 7/25/14 | | |
| | but was not limited to the following order: | | | | | | |
| | | | | | | | |
| | | rol 0.083% Inhalation | | | | | |
| | 3/20/17AIDUIC | ioi o.oos/v iiiialatioii | 1 | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 30 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MU | LTIPLE CO | NSTRUCTION | (X3) DATE | |
|--|---|------------------------------|---------|--------------|---|-----------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL 06/05/ | |
| | | | B. WINC | | | 06/05/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIEF | 3 | | | DDRESS, CITY, STATE, ZIP CODE | | |
| RITTENI | HOUSE SENIOR LI | VING OF INDIANAPOLIS | | | 96TH ST APOLIS, IN 46260 | | |
| | | TATEMENT OF DEFICIENCIES | | | 11 0210, 114 10200 | | (7/5) |
| (X4) ID PREFIX | | ICY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | RIATE DATE | |
| | Solution (A brea | athing treatment | | | | | |
| | medication that | helped dilate the lungs to | | | | | |
| | make breathing | easier). Inhale 3 ml | | | | | |
| | (milliliters) orall | ly three times daily | | | | | |
| | routinely. Scheo | duled for 8 A.M., 12 P.M. | | | | | |
| | and 4 P.M. During an interview on 6/4/14 at 1:40 P.M., the ARCD indicated she had given | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | the resident his 12 P.M., nebulizer | | | | | | |
| | treatment after 10 A.M., and she had signed it off on the MAR for the 12 P.M. | | | | | | |
| | | | | | | | |
| | | ated she had 90 minutes | | | | | |
| | | a scheduled medication | | | | | |
| | to give that med | | | | | | |
| | | e indicated she left the | | | | | |
| | _ | sed with dementia alone | | | | | |
| | with a nebulizer | cause she looked at her | | | | | |
| | | started the treatment, | | | | | |
| | | ack when the treatment | | | | | |
| | | in approximately 15 to 20 | | | | | |
| | | dicated she had given | | | | | |
| | | e 12 P.M., nebulizer | | | | | |
| | | due to he was short of | | | | | |
| | 1 | eft him alone during the | | | | | |
| | treatment after b | being short of breath to | | | | | |
| | accept a phone c | - | | | | | |
| | | | | | | | |
| | During an interv | riew on 6/4/14 at 3:20 | | | | | |
| | P.M., the Reside | ent Care Director (RCD) | | | | | |
| | indicated the ARCD should have stayed | | | | | | |
| | | t during the entire | | | | | |
| | nebulizer treatm | ent. She indicated the | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 31 of 47

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---------------------|--------------------------------|------------------|---|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | |
| | | | B. WING | | 06/05/2014 | |
| NA 25 0 = 5 | DOLUDED OF STATE | <u>I</u> | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIE | К | | V 96TH ST | | |
| RITTENH | HOUSE SENIOR L | IVING OF INDIANAPOLIS | INDIAN | NAPOLIS, IN 46260 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | · · | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | | hour before and after the | | | | |
| | | cation time to administer | | | | |
| | the medication. | | | | | |
| | Δ current notice | y dated 4/30/2008, titled | | | | |
| | | Administration : General | | | | |
| | | icated, "Process:12. | | | | |
| | | lications in accordance | | | | |
| | | s order. 13. All current | | | | |
| | | d dosages schedules are | | | | |
| | | ident's medication | | | | |
| | | less otherwise specified | | | | |
| | | re provider, administer | | | | |
| | 1 - | ions according to the | | | | |
| | | lication administration | | | | |
| | | Assisted Living | | | | |
| | | I agreed upon by the | | | | |
| | | ledications are taken | | | | |
| | | of the scheduled time | | | | |
| | | dered before, with or after | | | | |
| | meals" | acrea octore, with or after | | | | |
| | 1110015 | | | | | |
| | A current policy | y dated 11/15/2010, titled | | | | |
| | | lications: Observation" | | | | |
| | | cy: Observation and | | | | |
| | - | ne resident prior to, during | | | | |
| | | nebulizer treatment is | | | | |
| | _ | censed nursing staff" | | | | |
| | Conducted by III | consou nursing start | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 32 of 47

| | | IDENTIFICATION NUMBER: | A. BUILDING B. WING | | COMPLETED 06/05/2014 | |
|--------------------------|---|---|----------------------|--|----------------------|--|
| | PROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | 1251 V | ADDRESS, CITY, STATE, ZIP CODE W 96TH ST NAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| R000242 | effects of medication any undesirable effects of the clinical record. Notified immediate occur, and such not documented in the Based on observer record review, for receiving a nebulizer treatment monitor for adversed medication during nebulizer treatment. Findings include On 6/3/14 at 10: was observed sitt towards the hally | Offense hall be observed for ons. Documentation of fects shall be contained in The physician shall be ly if undesirable effects otification shall be e clinical record. ation, interview and or 1 resident observed lizer treatment out of 6 as residents who received ents the facility failed to are effects of a g the administration of a ent. (Resident #35) | R000242 | R 242 410 IAC 16.2-5-4 (e) (2 Health Services 1) What corrective action(s) will be accomplished for those reside found to have been affected b the deficient practice: Assessment during Medicatio Administration/ Nebulizer for: Resident #35: Is being monito during his medication administration/ Nebulizer Treatment. Licensed nurse, identified during survey, was educated on the policy for Nebulizer treatments. 2) Ho the facility will identify other residents having the potential be affected by the same defic practice and what corrective | ents by n pred to | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 33 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S | SURVEY |
|--|--|--------------------------------|---------|---|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDING | 00 | COMPL | ETED |
| | | | B. WIN | | | 06/05/ | 2014 |
| | | l . | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | | 96TH ST | | |
| RITTENI | HOUSE SENIOR LIV | VING OF INDIANAPOLIS | | | APOLIS, IN 46260 | | |
| | | | | | Al OLIO, IIV 40200 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | ICY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIAGE DEFICIENCY) | | ΓE | COMPLETION |
| TAG | <u> </u> | L LSC IDENTIFYING INFORMATION) | | TAG | · · | | DATE |
| | | r his mouth and nose. | | | action will be taken: All | ho | |
| | He was observed | d receiving a nebulizer | | | residents have the potential to affected. 3) What measure | | |
| | treatment (A bre | eathing treatment | | | will be put into place or what | | |
| | medication) with | nout any observed staff | | | systemic changes the facility v | vill | |
| | member in atten | dance. He had his right | | | make to ensure that the deficie | ent | |
| | | k at the nose area. | | | practice does not recur: | | |
| | | | | | Licensed nursing staff was | | |
| | At 10.22 A.M. 4 | the Assistant Resident | | | educated the policy and | | |
| | | | | | procedure for Nebulizer Treatments. 4) How the | | |
| | Care Director (ARCD) came into the resident's room and shut the nebulizer | | | | corrective action(s) will be | | |
| | | | | | monitored to ensure the deficie | ent | |
| | machine off. She took the mask off the | | | | practice will not recur, i.e., wha | at | |
| | resident and placed his glasses on his | | | | quality assurance program will | | |
| | face, then left th | e room. | | | put into place: The Resident C | are | |
| | | | | | Director or their designee will | | |
| | At 10:25 A.M., 1 | the ARCD came back | | | complete the observation repo weekly for four (4) weeks, ther | | |
| | into the resident | 's room and transported | | | one (1) time a month thereafte | | |
| | | vity room to join an | | | The results of this observation | | |
| | activity. | 3 | | | report for the performance of t | he | |
| | | | | | medication administration | | |
| | The regident's re | cord was reviewed on | | | (assessment during nebulizer | | |
| | | | | | treatments) will be discussed with the Executive Director or their | vith | |
| | 6/4/14 at 10:05 | • | | | designee during weekly | | |
| | _ · | ere not limited to, senile | | | management meeting for ongo | oina | |
| | · · | a, sleep apnea, debility | | | compliance. 5) By wh | | |
| | and depressive d | lisorder. | | | date the systemic changes will | | |
| | | | | | completed: Date of | | |
| | The June 2014, 1 | Medication | | | Completion: 7/25/14 | | |
| | Administration I | Record (MAR) included, | | | | | |
| | | ted to the following | | | | | |
| | order: | | | | | | |
| | | rol 0.083% Inhalation | | | | | |
| | | | | | | | |
| | Solution (A breathing treatment medication that helped dilate the lungs to | | | | | | |
| | | | | | | | |
| | _ | easier). Inhale 3 ml | | | | | |
| | (milliliters) orall | ly three times daily | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 34 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | | NSTRUCTION 00 | (X3) DATE : COMPL | | |
|--|---|--|------------------|---------------|---|--------|----------------------------|
| | | | B. WING | 9 | | 06/05/ | 2014 |
| | PROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | 12 | 51 W | ddress, city, state, zip code 96TH ST APOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREI TA | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | routinely. Schedand 4 P.M. | luled for 8 A.M.,12 P.M. | | | | | |
| | P.M., the ARCD residents diagnor with a nebulizer administered becwatch when she then she came be should be done i minutes. She incresident's temper (amount of oxyg sounds before an but she did not danywhere for schindicated after the was administered | rause she looked at her started the treatment, ack when the treatment in approximately 15 to 20 dicated she assessed the rature, oxygen saturation en in the blood) and lung and after each treatment, occument her assessments neduled treatments. She are nebulizer treatment in d on 6/3/14, she assessed agen saturation, but no | | | | | |
| | P.M., the RCD in ARCD to assess | ndicated she expected the the residents according creatment policy and | | | | | |
| | provided by the at 2:45 P.M., title Medications: Ob | servation" indicated, ation and assessment of | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 35 of 47

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: | | ILDING | 00 | COMPL 06/05/ | ETED |
|--------------------------|--|---|---|---------------------|---|-----------------|----------------------------|
| | PROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | • | 1251 W | DDRESS, CITY, STATE, ZIP CODE 96TH ST APOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | Purpose: To provindependence that and attention to rany adverse effect related to the treat Process: 1. Prior administration of medications, lice observe resident [oxygen] sats [sate auscultate lungs, Observe the residence of inade and the company of the provided by the Interest of the provided by the Interest of medication of Guidelines" indictions of the provided by the Interest of medication of the provided by the Interest of the provided observe the residence of the provided of the provided observe the residence of the provided observe t | ensed nursing staff mote resident health and rough early detection of, respiratory issues, and ets and health conditions atment administered. r to and following f inhaled nebulizer nsed nursing will respirations; check O2 turations], pulse and including whether2. dent's skin color for equate oxygen supply" | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 36 of 47

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION | | | ONSTRUCTION | (X3) DATE SURVEY | |
|---------------|--|---|---------------|--|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED | | |
| | | | B. WING | | 06/05/2014 | |
| NAME OF F | PROVIDER OR SUPPLIE | R | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | V 96TH ST | | |
| RITTENH | HOUSE SENIOR LI | IVING OF INDIANAPOLIS | INDIAN | NAPOLIS, IN 46260 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) | |
| PREFIX TAG | ` | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION DATE | |
| TAG | REGULATORT OF | R LSC IDENTIFTING INFORMATION) | TAG | | DATE | |
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| | | | | | | |
| R000273 | 410 IAC 16.2-5-5 | | | | | |
| | | onal Services - Deficiency | | | | |
| | | ration and serving areas in residents 'units) are | | | | |
| | | cordance with state and | | | | |
| | local sanitation a | nd safe food handling | | | | |
| | | ing 410 IAC 7-24. | | | | |
| | | vation, interview and | R000273 | D 273 /10 IAC 16 2 5 5 1 (A E. | 07/25/2014 | |
| | 1 | the facility failed to ensure | | R 273 410 IAC 16.2-5-5.1 (f) Fo | ou | |
| | _ | onment in the food | | | | |
| | | as of the kitchen. A cook | | | | |
| | had no hair cove | ering on, maintenance | | | | |
| | personnel had n | o hair covering on and | | | | |
| | changed a kitch | nen overhead light while | | 1) What corrective action(s) will | he | |
| | | | | 1) what corrective action(s) will | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 37 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF | | | | | |
|--|---|--|---------|----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | | B. WIN | | | 06/05/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | NO VIDER OR SUFFLIER | X. | | | 96TH ST | | |
| | | VING OF INDIANAPOLIS | _ | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | accomplished for those residents | | DATE |
| food was out and being prepared. This | | | | | found to have been affected by th | e | |
| | 1 | he potential to affect all | | | deficient practice: | • | |
| | | rently receiving food | | | • | | |
| | from the kitchen | | | | Hair Coverings for: | | |
| | Findings include | · | | | A. The staff member/Cook identi | fied | |
| | i mamga maraa | • | | | during survey, immediately comp | lied | |
| | During an initial kitchen observation on 6/3/14 at 9:55 A.M., FSA (Food Service | | | | with the hair covering policy. | | |
| | | | | | Dietary staff were in serviced on | | |
| | Assistant) #1 wh | no identified himself as | | | Hair Covering policy. The staff | | |
| | one of the cooks was observed without | | | | member (cook) received a correct | | |
| | hair covering. He indicated at the time | | | | action for non-compliance with h | air | |
| | he knew he was suppose to wear a hair | | | | covering policy | | |
| | covering but the | hair coverings would fly | | | B. Maintenance Personnel: | | |
| | off when he oper | ned the oven door. He | | | | | |
| | indicated there v | vere other hair nets | | | Maintenance and Housekeeping | | |
| | available. | | | | personal received in-service | | |
| | | | | | education on hair covering policy | • | |
| | On 6/3/14 at 11: | 15 A.M., in a second | | | | | |
| | kitchen observat | ion, the Maintenance | | | | | |
| | Director was obs | served changing a light | | | | | |
| | fixture with no h | air net on and during the | | | 2) How the facility will identify of | ther | |
| | active preparation | on of food near by. | | | residents having the potential to b | | |
| | | | | | affected by the same deficient | | |
| | During an interv | riew with the DDS | | | practice and what corrective action | n | |
| | (Director of Din | ing Services) on 6/4/14 at | | | will be taken: | | |
| | 3:30 P.M., she in | ndicated hair coverings | | | | | |
| | were to be worn | in the kitchen and she | | | | | |
| | was disappointed | d in the staff members | | | All residents have the potential to | be | |
| | | red not wearing hair | | | affected. | | |
| | | kitchen. She indicated | | | | | |
| | | e should not be changing | | | | | |
| | | ixtures and doing | | | | | |
| | non-essential wo | _ | | | | | |
| | | <i>G</i> 222 | | | | | |

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PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CO | | li i | ESURVEY |
|--|---------------------|--------------------------------|------------------|---|-------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | | LETED |
| | | | B. WING | | 06/05 | 5/2014 |
| NAME OF P | DOMDED OF GUIDNATE | | STREET | ADDRESS, CITY, STATE, ZIP CO | DE | |
| NAME OF P | ROVIDER OR SUPPLIER | X. | 1251 W | / 96TH ST | | |
| RITTENH | IOUSE SENIOR LI | VING OF INDIANAPOLIS | INDIAN | IAPOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | T | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP | ECTION OULD BE | COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | PROPRIATE | DATE |
| | preparation time | when food is out. | | 3) What measures will be | put into | |
| | PP | | | place or what systemic cha | anges the | |
| | The record of th | e facility's dietary | | facility will make to ensure | e that the | |
| | | cedures was reviewed on | | deficient practice does not | | |
| | | .M. The record dated | | Dietary staff educated/ in- | | |
| | | | | hair covering policy. Dieta Services Director and or th | - | |
| | | : "Dietary Policies and | | designee will completed th | | |
| | | icated, "All [name of | | Sanitation checklist section | | |
| | | ees preparing food, as | | Employees: Hair restraints | | |
| | | iduals entering food | | properly weekly. | | |
| | | s, shall have their hair | | | | |
| | | per manner at all times. | | | | |
| | Purpose to ensur | re a sanitary environment | | | | |
| | in areas directly | effecting the preparation | | | | |
| | of food items' | " | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | 4) How the corrective action | on(s) will | |
| | | | | be monitored to ensure the | | |
| | | | | practice will not recur, i.e. | | |
| | | | | quality assurance program | | |
| | | | | into place: | • | |
| | | | | | | |
| | | | | | | |
| | | | | Diatory Somions Director | and or | |
| | | | | Dietary Services Director their designee will comple | | |
| | | | | Dietary Sanitation checklis | | |
| | | | | Employees: Hair restraints | | |
| | | | | properly weekly. Results of | | |
| | | | | will be reviewed at weekly | | |
| | | | | management meeting. | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 39 of 47

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|--|--|---|---|--|-----------------------------|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | COMPLETED | | |
| | | | B. WING | | 06/05/2014 | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | / 96TH ST | | | |
| RITTENE | HOUSE SENIOR LIV | /ING OF INDIANAPOLIS | INDIAN | IAPOLIS, IN 46260 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR | NATE | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | | |
| | | | | 5) By what date the systemic ch will be completed: | nanges | | |
| | | | | Date of Completion: 7/25/14 | | | |
| R000306 | (g) Medications ac shall be disposed appropriate federa and disposition of destroyed medica in the resident 's cinclude the followi (1) The name of the (2) The name and (3) The prescription (4) The reason for (5) The amount di (6) The method of (7) The date of the (8) The signature the disposal of the (9) The signature disposal of the drub Based on record the facility failed resident's clinical of a resident's million. | ervices - Noncompliance dministered by the facility in compliance with al, state, and local laws, any released, returned, or tion shall be documented clinical record and shall ng information: he resident. strength of the drug. In number. disposal. sposed of. disposition. disposal. of the person conducting e drug. of a witness, if any, to the lig. review and interview, all to document in the light record the disposition edications for 1 of 2 and for the disposition of the person of the disposition dedications for 1 of 2 and for disposition of the disposition | R000306 | R306 410 IAC 16.2-5-6(g) (1 Pharmaceutical Services What corrective action(s) will accomplished for those resid found to have been affected the deficient practice: Dispos of Medications Resident # Family member of discharge resident #41 was contacted a | 1) I be Ients by Sition 41: | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 40 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE S | URVEY | |
|--|----------------------|------------------------------|--------------------|------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPLE | ETED |
| | | | A. BUIL B. WING | | | 06/05/2 | 2014 |
| | | | B. WINC | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | | | |
| DITTENII | 10116E 6EM10D 1 1/ | INC OF INDIANADOUS | | | 96TH ST | | |
| RITTENE | 100SE SENIOR LIV | /ING OF INDIANAPOLIS | | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | 1 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | | | | verbally verified the disposition | | |
| Findings include: | | | | | medications. Licensed Nurs | | |
| | i mamga merade | • | | | received in-service education | | |
| | D: 1 / // / / / / | | | | include the "Policy on Disposit | | |
| | | ecord was reviewed on | | | of Medications" 2) How the | | |
| | | M. Diagnoses included, | | | facility will identify other reside | | |
| | but was not limit | ted to, chronic back pain, | | | having the potential to be affective | | |
| | diabetes, Alzheir | ner's dementia, | | | by the same deficient practice and what corrective action will | | |
| | • | depression and history | | | taken: All residents have the | | |
| | | dium Difficile-a bowel | | | potential to be affected. 3) | | |
| | ` | didili Difficiic-a uuwei | | | What measures will be put into | | |
| | infection). | | | | place or what systemic change | | |
| | | | | | the facility will make to ensure | | |
| | Resident's nurses | s notes indicate on | | | that the deficient practice does | | |
| | 2/4/14, "Res [res | ident] very lethargic | | | not recur: All discharged med | | |
| | BS[blood sugar] | | | | charts will be audited to ensur | e | |
| | | o hospitalres was | | | proper documentation of the | | |
| | | • | | | disposition of medication. | 4) | |
| | · ' | ydration" On 3/25/14 | | | How the corrective action(s) w | rill | |
| | | ndicated, "Res expired at | | | be monitored to ensure the | | |
| | [name of the fact | ility]" On 4/1/14 the | | | deficient practice will not recur | , | |
| | nurse's note indi | cated, "Res property | | | i.e., what quality assurance | | |
| | | nily, release of property | | | program will be put into place: Discharge Resident checklist | | |
| | signed." | 5 / F | | | be used to monitor compliance | | |
| | bigiiou. | | | | with disposition of medications | | |
| | ma | 11 1 1 0 | | | Resident Care Director and or | | |
| | | cord lacked information | | | their designee will review | | |
| | regarding the dis | sposition of the resident's | | | Discharge Resident Checklist | | |
| | medications. Re | cords were requested at | | | weekly for four (4) weeks then | | |
| | this time. | | | | one (1) time a month thereafte | er. | |
| | | | | | The results of the review of | | |
| | As of evit on 6/5 | 7/14 at 6:20 P.M., no | | | the Discharge Resident Check | | |
| | | • | | | will be discussed with Executive | | |
| | • | vided that indicated | | | Director or their designee during | | |
| | what happened to | o the resident's | | | weekly management meeting compliance. 5) E | | |
| | medications. | | | | what date the systemic change | - | |
| | | | | | will be completed: Date of | | |
| | | | | | Completion: 7/25/14 | | |
| | | | | | r | | |
| | | | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 41 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED | | | | | |
|--|--|--|----------|--------|---|----------------------|------------|
| | | | B. WINC | | | 06/05/ | 2014 |
| | ROVIDER OR SUPPLIER | /ING OF INDIANAPOLIS | | 1251 W | DDRESS, CITY, STATE, ZIP CODE 96TH ST APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | FATEMENT OF DEFICIENCIES | _ | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| R000354 | (3) Name of the redate of transfer. (4) Resident's per transferred to an area (5) Nurses' notes is: (A) functional abilitimitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and (6) Diagnosis. (7) Date of chest is tuberculosis. Based on interviet the facility failed transfer documented for for interfacility trand #59) Findings include 1. Resident #59' on 6/4/14 at 12:1 | Noncompliance shall include the shall include th | R000 | 0354 | R354 410 IAC 16.2-5-8.1 (g) (1-7) Clinical Records 1) What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice: Transfer Records Resident #9: Was transferred in an urgent status and documentation not transcribed on the Transfer packet. Resident #59: Was transferred in an urgent status and documentation not transcribed on the Transfer packet. Resident #59: Was transferred in an urgent status and documentation not transcribed on the Transfer Fo was included in her transfer packet. Licensed Nurses strengive in service education to | nts y rm rm | 07/25/2014 |
| | | | | | receive in-service education to |) | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 42 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | |
|--|----------------------|------------------------------|---|--------|---|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DI 111 | LDING | 00 | COMPL | ETED |
| | | | A. BUII B. WIN | | | 06/05/ | 2014 |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | 96TH ST | | |
| RITTEN | HOUSE SENIOR LI | VING OF INDIANAPOLIS | | | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | 1 | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | A "Patient Tran | sfer Form" indicated the | | | include the proper completion | of | |
| | resident was bei | ng transferred to [name | | | Transfer/ Discharge | | |
| | of hospital] on 4 | /17/14. This form lacked | | | documentation. 2) How the facility will identify other reside | nte | |
| | the following in | | | | having the potential to be affect | | |
| | _ | the resident's personal | | | by the same deficient practice | | |
| | | ransferred to the acute | | | and what corrective action will | | |
| | | ectional abilities and | | | taken: All residents have the | Э | |
| | _ | ons of the resident and an | | | potential to be affected. 3) | | |
| | | ne resident's Physician | | | What measures will be put into place or what systemic change | | |
| | _ | | | | the facility will make to ensure | | |
| | | ions and when they were | | | that the deficient practice does | | |
| | | d. The dates of her last | | | not recur: Licensed Nurses sh | | |
| | _ | tuberculin skin test. The | | | receive in-service education to | | |
| | _ | se had not signed or dated | | | include the proper completion | of | |
| | the transfer form | 1. | | | Transfer/ Discharge documentation. Discharging | | |
| | | | | | nurse will indicate on twenty-fo | our | |
| | During an interv | riew on 6/4/14 at 3:20 | | | hour report, proper completion | | |
| | P.M., the Reside | ent Care Director | | | | l) | |
| | indicated she ha | d expected the nurse that | | | How the corrective action(s) w | ill | |
| | | esident to the receiving | | | be monitored to ensure the | | |
| | | filled the transfer form | | | deficient practice will not recur i.e., what quality assurance | , | |
| | | aired information, signed | | | program will be put into place: | | |
| | 1 | rm.2. Resident #9's | | | Resident Care Director and or | | |
| | | ewed on $6/3/14$ at 3 P.M. | | | their designee will review the | | |
| | | ded, but were not limited | | | transfer forms for proper | | |
| | • | | | | completion weekly for four (4) weeks then one (1) time a mo | onth | |
| | • | al vascular accident or | | | thereafter. The results of the | 11111 | |
| | 1 | disorder, and high | | | review will discuss with Execu | tive | |
| | blood pressure. | | | | Director or their designee at | - | |
| | | | | | weekly management meeting | for | |
| | The resident's re | cord indicates under | | | ongoing compliance. | 5) | |
| | nurse's notes for | 1/27/14 at 1 P.M., "res | | | By what date the systemic | | |
| | [resident] found | on floor in dining room | | | changes will be completed: Date of Completion: 7/25/14 | | |
| | in sitting positio | n [symbol for with] | | | Date of Completion. 1/23/14 | | |
| | [symbol for no] | pain, a laceration to | | | | | |
| | | middle finger the whole | | | | | |
| | [[] | | 1 | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 43 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULT | TIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|--|----------------------|--|-----------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | 00 | COMPL | ETED |
| | | | B. WING | 0 | | 06/05/ | 2014 |
| | | | | STREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIEF | · · | | | 96TH ST | | |
| | | VING OF INDIANAPOLIS | | NDIAN | APOLIS, IN 46260 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | EFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | 1 | ΓAG | DEFICIENCY) | | DATE |
| | | e. Order to send to ER | | | | | |
| | [Emergency Roo | om] for eval | | | | | |
| [evaluation]" | | | | | | | |
| | | | | | | | |
| | | arse's notes dated 1/27/14 | | | | | |
| | · · | ited,"notifiedresident is | | | | | |
| | | symbol for with] | | | | | |
| | multiple pelvic f | fx [fracture], fx wrist and | | | | | |
| | fx thumb" | | | | | | |
| | | | | | | | |
| | Resident #9's tra | insfer form contained | | | | | |
| | only the resident | t's name, current address | | | | | |
| | and vital signs. | | | | | | |
| | | | | | | | |
| | The transfer form | n lacked the name of the | | | | | |
| | | tion, notes relating to the | | | | | |
| | _ | oses at time of transfer, | | | | | |
| | functional abiliti | | | | | | |
| | | ications, treatments, diet, | | | | | |
| | · · | ay and skin test for | | | | | |
| | tuberculosis. | ay and skin test for | | | | | |
| | tuoticulosis. | | | | | | |
| | During an interv | riew with the | | | | | |
| | _ | Care Director) on 6/5/14 | | | | | |
| | ` · | * | | | | | |
| | · · | e indicated how much | | | | | |
| | | lled out on the transfer | | | | | |
| | forms varied. | | | | | | |
| R000410 | 410 IAC 16.2-5-12 | 2(e)(f)(a) | | | | | |
| | Infection Control - | | | | | | |
| | (e) In addition, a t | uberculin skin test shall be | | | | | |
| | | three (3) months prior to | | | | | |
| | | n admission and read at | | | | | |
| | | seventy-two (72) hours. e recorded in millimeters of | | | | | |
| | | e date given, date read, | | | | | |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 44 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED | | | |
|--|---------------------------------------|--|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | |
| | | | B. WING | | 06/05/2014 |
| NAME OF P | PROVIDER OR SUPPLIEF | _ | | ADDRESS, CITY, STATE, ZIP CODE | |
| DITTENIL | JOHNE SENIOD LIN | VING OF INDIANAPOLIS | | V 96TH ST NAPOLIS, IN 46260 | |
| | | | | NAF OLIO, IIN 40200 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | RIATE |
| TAG | | ninistered and read. | TAG | DEFICIENCY) | DATE |
| | , | ho have not had a | | | |
| | ` ' | ative tuberculin skin test | | | |
| | result during the p | preceding twelve (12) | | | |
| | | line tuberculin skin testing | | | |
| | | e two-step method. If the ve, a second test should | | | |
| | | nin one (1) to three (3) | | | |
| | | st test. The frequency of | | | |
| | | depend on the risk of | | | |
| | infection with tube | | | | |
| | | ho have a positive reaction kin test shall be required | | | |
| | | ray and other physical and | | | |
| | | ations in order to complete | | | |
| | a diagnosis. | · | | | |
| | Based on intervi | ew and record review, | R000410 | R410 410 IAC 16.2-5-12 (e | |
| | the facility failed | d to ensure 3 of 6 | | ,, | What |
| | residents receive | ed a first or second step | | corrective action(s) will be accomplished for those residuals. | dents |
| | tuberculin skin t | est prior to or upon | | found to have been affected | |
| | admission to the | facility. (Residents #11, | | the deficient practice: TB | |
| | #35 and #59) | | | Testing? Resident #11: F | |
| | | | | and second step Tuberculin test was re-administered. | SKIN |
| | Findings include | 2. | | Resident #35: First and seco | ond |
| | | | | step Tuberculin skin test wa | |
| | 1. Resident #11 | 's record was reviewed | | re-administered Resident # | 59: |
| | | 2 P.M. Diagnoses | | First and second step Tuber | |
| | | ere not limited to, | | skin test was re-administere Licensed Nurses shall recei | |
| | • | s Type II, dementia, | | in-service education to inclu | - |
| | depression and a | • • • | | the "Policy on Infection Conf | |
| | acpression and a | ······································ | | TB Testing" 2) How the fa | ncility |
| | The "Nursing A | dmission Assessment" | | will identify other residents h | |
| | _ | dicated the resident was | | the potential to be affected to same deficient practice and | - |
| | · · · · · · · · · · · · · · · · · · · | Facility on 9/4/13. | | corrective action will be take | |
| | aumition to the I | acmity on 7/4/13. | | All residents have the poten | |
| | The "Desident T | D/Immunization Dagged! | | be affected. 3) What | |
| | | B/Immunization Record" | | measures will be put into pla | |
| | indicated the firs | st step tuberculin test was | | what systemic changes the | facility |

State Form Event ID: VVFR11 Facility ID: 003282 If continuation sheet Page 45 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | SURVEY |
|--|----------------------|------------------------------|---|--------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | DDIC | 00 | COMPL | ETED |
| | | | A. BUII | | | 06/05/ | /2014 |
| | | | B. WIN | | DDDECC CITY CTATE ZID CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| DITTENI | IOLIGE GENIOD I II | WIND OF INIDIANADOLIO | | | 96TH ST | | |
| KILLENE | HOUSE SENIOR LI | VING OF INDIANAPOLIS | | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ГЕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | placed on 9/4/13 | . The "Resident | | | will make to ensure that the | | |
| | TB/Immunization | on Record" lacked | | | deficient practice does not rec | | |
| | documentation of | | | | Admitting nurse will utilized the | | |
| | tuberculin skin t | _ | | | admission checklist to ensure | | |
| | tubercumi skin t | est. | | | Testing completed, per policy | and | |
| | | | | | recorded on medication administration record. | | |
| | | riew on 6/5/14 at 4:15 | | | 4) How the corrective action(s) |) | |
| | P.M., the Reside | ent Care Director (RCD) | | | will be monitored to ensure the | | |
| | indicated the res | ident did not receive a | | | deficient practice will not recur | | |
| | second step tube | erculin skin test | | | i.e., what quality assurance | | |
| | | to or upon admission. | | | program will be put into place: | | |
| | | er first and second step | | | Resident Care Director and or | | |
| | | • | | | designee will review admission | ו | |
| | tuberculin skin t | C | | | checklist weekly for four (4) | 41- | |
| | re-administered | as of today. | | | weeks then one (1)time a mon thereafter. The results of the | tn | |
| | | | | | review will be discussed with | | |
| | 2. Resident #35 | 's record was reviewed | | | Executive Director or their | | |
| | on 6/4/14 at 10:0 | 05 A.M. Diagnoses | | | designee at weekly manageme | ent | |
| | | ere not limited to, senile | | | meeting, to ensure compliance | | |
| | · · | a, depressive disorder, | | | with TB testing. 5) By | | |
| | diabetes mellitus | • | | | what date the systemic change | es | |
| | diabetes illellitus | s and debinty. | | | will be completed: Date of | | |
| | | | | | Completion: 7/25/14 | | |
| | | 'B/Immunization Form" | | | | | |
| | indicated the res | ident was admitted to the | | | | | |
| | facility on 9/27/ | 13. | | | | | |
| | | | | | | | |
| | The "Resident T | B/Immunization Form" | | | | | |
| | | st step tuberculin skin test | | | | | |
| | | • | | | | | |
| | was completed of | JII 7/3U/13. | | | | | |
| | | | | | | | |
| | _ | riew on 6/5/14 at 9:10 | | | | | |
| | A.M., the RCD | indicated there was no | | | | | |
| | other tuberculin | skin test documentation | | | | | |
| | found for the res | sident other than the | | | | | |
| | | in skin test. She | | | | | |
| | | | | | | | |
| | marcaled ne did | not get a tuberculin skin | | | | | |

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PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 06/05/2014 | |
|--|---|--|---------------------|---|---------------|
| NAME OF P | ROVIDER OR SUPPLIEF | 1 | | ADDRESS, CITY, STATE, ZIP CODE // 96TH ST | |
| RITTENH | OUSE SENIOR LI | VING OF INDIANAPOLIS | | APOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE COMPLETION |
| | test prior to or up facility. | pon admission to the | | | |
| | on 6/4/14 at 12:1 included, but we | 's record was reviewed 13 P.M. Diagnoses are not limited to, fibrillation, hypertension, al regurgitation. | | | |
| | The resident's "Facesheet" indicated the resident was admitted to the facility on 3/31/14. | | | | |
| | was not located. The resident's redocumentation to | hat a first and/or second kin test had been placed | | | |
| | A.M., the RCD is her first step tub transferring facil receive her second test after she arri | _ | | | |

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